MINISTRY OF HEALTH
SINGAPORE

MH 34:24/8 MOH Circular No. 07/2022

22 January 2022

See Distribution List

STREAMLINING OF COVID-19 HEALTHCARE PROTOCOLS

This circular updates on the further streamlining of our national healthcare protocols for COVID-19, which will come into effect **with immediate effect**:

i. **Expanded eligibility criteria** for Protocol 2 (Primary Care) (P2PC). The expanded criteria will allow suitably fit children aged 5 to 11 years old, including both fully vaccinated and unvaccinated, to be managed under P2PC.

ii. **Aligning the testing strategy and management of all low-risk individuals** to the national healthcare protocols, including Pre-Event Testing (PET), Rostered Routine Testing (RRT), Pre-Departure Testing (PDT), On-Arrival Testing (OAT) and Stay-Home Notice (SHN) exit tests).

iii. Shortening the maximum isolation duration for fully vaccinated individuals and children aged <12 years old from **10 to 7 days** and **aligning the de-isolation criteria across Protocols 1 and 2.**

iv. **Ceasing the issuance of medical certificates (MC(s)) with the Stay Order requirement** to patients with acute respiratory infection (ARI) symptoms under Protocol 1.

Expanded Eligibility Criteria for Protocol 2 (Primary Care)

2. Since 6 January 2022, we have revised our Healthcare Protocols to streamline the management of COVID-19 cases according to the severity of symptoms and individual health status, in partnership with primary care doctors. Low-risk individuals with mild symptoms are immediately diagnosed via a healthcare-administered Antigen

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Rapid Test (ART) and recover safely under **Protocol 2 (Primary Care)** [1](see MOH Circular 04/2022)**;** whilst those who are assessed by their doctors as higher risk (e.g. elderly, pregnant, immunocompromised status, etc) or with significant symptoms (e.g. chest pain, shortness of breath, prolonged fever, etc) are managed under Protocol 1. Higher risk patients under Protocol 1 will undergo further assessment on whether they are eligible for MOH's Home Recovery Programme or need to be conveyed to a care facility. Low-risk individuals who are asymptomatic and test positive, including those who test positive on self-administered ARTs, will continue to be managed under Protocol 2. The intent is to right site clinical care and support individuals in returning to normal activities as soon as possible.

3. A phased approach was adopted to support a smooth roll-out. With more local clinical data available on the paediatric population and how they respond to COVID-19, the P2PC eligibility criteria will be expanded to include low-risk **children aged 5 to 11 years old (both fully vaccinated and unvaccinated)**, with immediate effect. For the month of December, only 3.2% of children aged 5-11 years old required conveyance to a care facility. Of the remaining children aged 5-11 years old who were subsequently enrolled onto HRP, only 5% of them requested for a follow-up Telemedicine consult. The vast majority of children aged 5-11 recovered uneventfully.

4. For the avoidance of doubt and as articulated in MOH circular 06/2022 "Updates to Booster Vaccination Recommendation" dated 12 January 2022, we will be aligning the definition of "Fully Vaccinated" to include the new booster requirements. This new definition will take effect from **14 February 2022** (as aligned to the Vaccine Differentiated SMMs) and will be used to identify high-risk patients (i.e. Fully Vaccinated individuals aged 80 years old and above OR partially vaccinated/unvaccinated individuals aged 50 years old and above).

Aligning Testing Strategy and Management of Low-Risk Individuals

5. Medical practitioners should assess and triage all individuals who test ART or PCR positive into the appropriate care protocol based on the severity of symptoms and/or medical risk factors (see **Annex A** for the revised triage criteria for Adults (≥12 years old) and Children (<12 years old), and **Annex B** for clinical package). Medical professionals should continue to use the appropriate IT system for their setting (e.g. PRPP for GP clinics) to submit the Protocol tag for patients; please do so as soon as possible after the clinical consultation so that appropriate and timely care management could be provided for the patients. For those who are higher risk or with symptoms of concern, the care involved and subsequent public health actions by MOH remain unchanged. If the doctor assesses the patient to be unwell or requiring higher levels of medical care, please contact CMTG at **64354060**[2] or

[1] Dormitory-dwelling migrant workers will recover at appropriate care settings stratified by risks and symptoms. For example, vaccinated dormitory-dwelling migrant workers eligible for Protocol 2 (Primary Care) will safely recover at dedicated dormitory recovery facilities coordinated by the Ministry of Manpower.

[2] Please note that this contact number is not for public.

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CMTG_call_centre@moh.gov.sg to arrange for conveyance. Please contact 995 as per existing approach if the patient is unstable.

6. In line with the updated national protocols, we will continue to gradually expand Protocol 2 to be the default mode of recovery for all remaining low-risk and asymptomatic individuals who test positive on COVID-19 ARTs or Polymerase Chain Reaction (PCR) tests. This alignment will encompass **all tests, including Pre-departure Testing (PDT), Pre-event Testing (PET), Routine Rostered Testing (RRT tests), On-arrival Testing (OAT) and other mandatory tests required as part of the Stay-Home Notices (SHNs)[3].** As more individuals undergo self-testing and testing at non-clinical test centres/non-clinical licensed providers (i.e. without a doctor), MOH has developed a list of easy-to-understand conditions for the public and sector leads to self-identify potentially at-risk individuals. The recommendation is for individuals with these conditions to see a doctor for further assessment, even if they are feeling well (See **Annex C** for the list of conditions)

7. If a symptomatic incoming traveller is placed on a healthcare protocol by a medical practitioner after testing ART or PCR positive via healthcare-administered test, the healthcare protocol will supersede their traveller testing/ isolation requirements. For example, if a traveller serving a 7-day Stay-Home Notice becomes unwell and was placed on P2PC after seeking medical help on Day 2, they may exit self-isolation after 72 hours (on Day 5) if they test negative on a self-administered ART. For the avoidance of doubt, this circular will supersede MOH CIRCULAR 70/2021 titled "Revised Suspect Case Criteria and Updated Guidance for COVID-19 Testing and Management of Tested Persons", dated 7 June 2021. All testing performed in the community-setting will follow the streamlined national protocols. So as an example, any individuals who have a travel history for the past 14 days and present with ARI symptoms need not have a mandatory PCR swab and should be triaged according to P1 or P2PC, depending on the patient's risk status and symptoms.

8. Persons tested positive through P1 PCR+, P2PC (ART+/PCR+) and P2 PCR+ would also be recognised as recovered from COVID-19 infection. Under current recovered policy, fully vaccinated recovered individuals are exempted from RRT and HRW and unvaccinated recovered individuals would be eligible for Vaccination-Differentiated Safe Management Measures (VDS) for 180 days from day of first PCR positive test result or healthcare-administered ART positive result. A memo (**Annex D**) should be provided to unvaccinated recovered individuals under P2PC for VDS purposes if the individual self-tests negative after Day 3.

[3] Although Medical practitioners can triage all patients in accordance to national protocols from 22 Jan onwards. A phased approach will be taken for non-clinical test centres, to ensure smooth transition in ground operations by the different sector leads. Low risks individuals undergoing tests at Combined Test Centres, Quick Test Centres and at border entry-points as part of On-arrival Testing, will be tagged as Protocol 2 by default from 31st January 2022 onwards.

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Shortening the Isolation Period and Alignment of De-isolation Criteria Across Protocols 1 and 2

9. Local and international studies have shown that the Omicron-variant is highly transmissible but less severe than Delta. The Omicron variant has also rapidly overtaken the Delta variant as the dominant local strain. Studies conducted by NCID show that most patients tested on Day 7 and beyond have low viral loads. As such, the maximum isolation period for fully-vaccinated individuals, and for all children below 12 years old, will be reduced from the current 10 days to **7 days**, with immediate effect. There will be no change to the 14-day maximum isolation period for unvaccinated or partially vaccinated individuals aged 12 years old and above. This applies to Protocol 1, P2PC and Protocol 2.

10. As part of our next step towards living with COVID-19 and supporting earlier return to activities for those who have recovered, we will be aligning the de-isolation criteria for Protocol 1 to that of P2PC and P2s, The following changes will come into effect immediately:

a. Discharge memos (DM) will no longer be issued to persons testing positive for COVID-19. All facilities and medical professionals can consider issuing the Recovery Memo (RM) (See **Annex D**), as needed.

b. In general, **suitably fit patients** (i.e. afebrile with resolving symptoms and clinically improving) can be discharged from hospitals, COVID-19 Treatment Facilities (CTFs), Community Isolation Facilities (CIFs) and Home Recovery Programme via a negative self-administered Antigen Rapid Test (ART) performed **at least 72 hours** after their first positive COVID test, OR until a time-based discharge at 12 noon on **Day 7** (for fully vaccinated individuals and all children under the age of 12) or **Day 14** (for unvaccinated / partially vaccinated individuals aged 12 and above), whichever is earlier. No further isolation is required after discharge. These patients may be issued a Medical Certificate for a duration that is clinically appropriate. This discharge/de-isolation regime is as aligned to current Protocol 2 (Primary Care) and Protocol 2. (See **Annex E** for a patient information sheet that can be given to patients being decanted from hospital/CTF into HRP)

c. Patients who are clinically unwell (i.e. still febrile, persistent symptoms) OR have not met the above de-isolation criteria (i.e. less than 72 hours stay in the facility OR test ART positive) may be decanted to the next appropriate level of care (i.e. Hospital→CTF, Hospital→HRP, or CTF→HRP) and continue to follow the discharge/deisolation procedure listed in the preceding paragraph 11(b).

d. All patients who are on Protocol 1 and Protocol 2 (Primary Care) will be able to obtain ART kits from vending machines islandwide. In line with the reduced isolation period, **three** kits will be issued instead of the current six. (See **Annex F** for a patient information sheet that can be given to patients being managed under P2PC)

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e. **Annex G** summarizes the respective patient journeys.

11. The above discharge/de-isolation criteria only applies to community settings. MOH will engage specific sector leads and agencies on the necessary safeguards needed before discharging or decanting COVID-19 patients into potentially high-risk or vulnerable settings, including nursing homes, intermediate/long-term care facilities, and intra/inter-hospital transfers.

Ceasing the Issuance of MCs with the Stay Order Requirement to Patients with ARI Symptoms under Protocol 1

12. Along with this revision of the care protocols, **doctors are to cease issuing MCs with the Stay Order requirement to patients with ARI symptoms.** This change will apply to all patients, including those who would fulfill the criteria of Protocol 1. This change also extends to patients with ARI symptoms who do not undergo SARS-CoV-2 PCR swabs, and those who are pending their PCR results. MCs for ARI symptoms should also **no longer indicate** (a) the written reminder that their recipients are legally required to stay home; or (b) the phrase "Protocol 1" (or words to that effect). Nevertheless, **doctors should still advise patients with ARI symptoms that they may be infected with COVID-19** and that they ought to isolate at home and avoid exposing others to the risk of infection for the duration of the MC.

Conclusion

13. With the expanded eligibility criteria for P2PC and streamlining of the national healthcare policies, the revised COVID-19 care protocols will better enable us to better care for our patients and focus our healthcare resources for high-risk and unwell individuals. We appreciate the patience and support of healthcare providers as we adapt our care protocols to the evolving COVID-19 situation. If there are any further clarifications, please call **6916 0193** [GP hotline] for more information.

A/PROF KENNETH MAK
DIRECTOR OF MEDICAL SERVICES
MINISTRY OF HEALTH

This Circular supersedes the following circulars:

MOH CIRCULAR 04/2022 titled "Update on the Management of COVID-19 with Protocol 2 (Primary Care)"

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MOH CIRCULAR 70/2021 titled "Revised Suspect Case Criteria and Updated Guidance for COVID-19 Testing and Management of Tested Persons", dated 7 June 2021, and circulars referred to on the issuance of MCs which carry a legal requirement to stay home for ARI symptoms

MOH CIRCULAR 70B/2021 titled "Addendum to Circular 70/2021: Removal of Public Health Actions Required Following a Positive COVID-19 Serology Test", dated 9 October 2021.

MOH CIRCULAR 174/2020 titled "UPDATES ON THE LEGAL REQUIREMENT FOR PATIENTS ISSUED WITH MEDICAL CERTIFICATES FOR ACUTE RESPIRATORY SYMPTOMS TO STAY HOME", dated 30 June 2020

MOH CIRCULAR 202/2020 titled "UPDATES TO MEDICAL CERTIFICATES ISSUED TO PATIENTS WITH ACUTE RESPIRATORY SYMPTOMS", dated 6 October 2020.

Distribution List

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Annexes

Annex A	UPDATED TRIAGE MATRIX (Attached within)
Annex B	UPDATED PRIMARY CARE DOCTOR – COVID-19 CLINICAL PACKAGE (Attached within)
Annex C	CONDITIONS THAT WOULD BENEFIT FROM FURTHER CLINICAL ASSESSMENT (Attached within)
Annex D	MEMO ON CONFIRMED COVID-19 INFECTION AND RECOVERY FOR UNVACCINATED INDIVIDUALS (Separate Attachment)
Annex E	PATIENT INFORMATION SHEET FOR PATIENTS BEING DECANTED FROM HOSPITAL/CTF INTO HRP (Separate Attachment)
Annex F	UPDATED PATIENT INFORMATION SHEET FOR PATIENTS ON PROTOCOL 2 (PRIMARY CARE) (Separate Attachment)
Annex G	PATIENTS' JOURNEYS (Attached within)
Annex H	UPDATED FREQUENTLY ASKED QUESTIONS (Attached within)

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Annex A

TRIAGE CRITERIA

Decision Matrix for Primary Care Doctors in Handling ARI Patients and Asymptomatic Patients Undergoing COVID-19 Tests

	ARI Workflow		Asymptomatic Testing for Public Health Reasons (PDT/PET/RRT/HRW)
	Symptoms/Signs of Concern	**Mild Symptoms**	
High Risk patient	**Protocol 1** (Double Swabs – ART AND PCR)	**Protocol 1** (Double Swabs – ART AND PCR)	**Protocol 1** (Ensure confirmatory PCR swab performed if only ART+)
Intermediate Risk patient	**Protocol 1** (Double Swabs – ART AND PCR)	**Protocol 1** (Double Swabs – ART AND PCR)	**Protocol 2** (Either ART+ or PCR+)
Low Risk patient	**Protocol 1** (Double Swabs – ART AND PCR)	**Protocol 2 (Primary Care)** (Only ART+ needed)	**Protocol 2** (Either ART+ or PCR+)

* Refer to tables below for screening criteria for Adult and Children respectively

ADULT (≥12 years old) Risk Criteria

- **High Risk – Not Suitable for recovery at home**
  - Prevailing Ineligible Criteria for Adults
    - Vaccinated ≥80 years old
    - Unvaccinated ≥50 years old
  - Comorbidities of Concern
    - Bone marrow/Organ transplant on immunosuppressant
    - Active/current cancer on chemotherapy/treatment
    - Leukemia/lymphoma/other hematological malignancies
    - Disease or medications that suppress immune system
    - Advanced/untreated HIV or AIDS
    - ESRF on dialysis
    - Chronic organ disease at high risk of deterioration e.g Decompensated Congestive Heart failure, Liver failure, COPD
- **Intermediate Risk – Benefit from closer monitoring under HRP-Enhanced**
  - Obesity: (BMI >35 or Weight >100kg)
  - Poorly Controlled DM
  - Pregnant
  - Vaccinated 70-79 years old

ADULT Symptoms/Signs of Concern

- **Symptoms**
  - Shortness of breath
  - Chest pain
  - Acute stroke symptoms
  - Chest palpitations
  - Symptoms suggestive of DVT
  - Severe headache not better with pain meds
  - Persistent diarrhea/vomiting/unable to take in fluids
  - Persistent Fever ≥ 3 days (≥38 degrees Celsius)
- **Signs**
  - Tachycardia >100
  - Tachypnoea >20
  - Hypotension <100mmHg
  - SPO2 ≤ 94%

*Doctor to exercise clinical judgement on whether to activate 995 vs 993 (via CMTG)

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PAEDS (<12 years old) Risk Criteria

- **High Risk – Not Suitable for recovery at home**
  - Prevailing Ineligible Criteria for Children
    - <3 months old
  - Comorbidities of Concern
    - Bone marrow/Organ transplant on immunosuppressant
    - Active/current cancer on chemotherapy/treatment
    - Leukemia/lymphoma/other heamotological malignancies
    - Disease or medications that suppress immune system
    - ESRF on dialysis
    - Poorly-controlled DM
    - Poorly-controlled HTN
    - Chronic/congenital respiratory conditions e.g. OSA, Chronic Lung Disease
    - Congenital heart/circulatory conditions
    - Neurodevelopmental conditions
- **Intermediate Risk – Benefit from closer monitoring under HRP-Enhanced**
  - Obesity: (BMI >27.5)
  - Children 3 months to 5 years old

PAEDS Symptoms/Signs of Concern

- **Symptoms**
  - Chest Pain
  - Shortness of Breath
  - Chest Palpitations
  - Drowsy/lethargic
  - High Fever >40°C
  - Prolonged Fever >38°C (continuously for 5 days or more)
  - Significant pain/discomfort anywhere
  - Headache worse than usual or not better with usual pain medications
  - Prolonged respiratory symptoms for 5 days or more
  - Persistent diarrhea/vomiting/abdominal pain and unable to take fluids (clinically unwell and fluid intake <50%)
  - Dehydrated - Poor urine output (<4 times/day)
  - Concerns of MIS-C/Kawasaki Disease
- **Signs**
  - SPO2 ≤ 94%
  - Tachycardia (Refer to table below)
  - Tachypnea (Refer to table below)

AGE	HEART RATE		RESPIRATORY RATE	
	Minimum	Maximum	Minimum	Maximum
Birth – < 3 months	90	180	30	60
3 months – < 6 months	80	160	30	60
6 months – <1 year	80	140	25	45
1 year – < 6 years	75	130	20	30
6 years – < 10 years	70	110	16	24
10 years – < 15 years	60	90	14	20
15 years and above	60	90	12	16

*Doctor to exercise clinical judgement on whether to activate 995 vs 993 (via CMTG)

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ANNEX B

PRIMARY CARE DOCTOR - COVID-19 CLINICAL PACKAGE

GENERAL GUIDE AND INSTRUCTIONS FOR USAGE

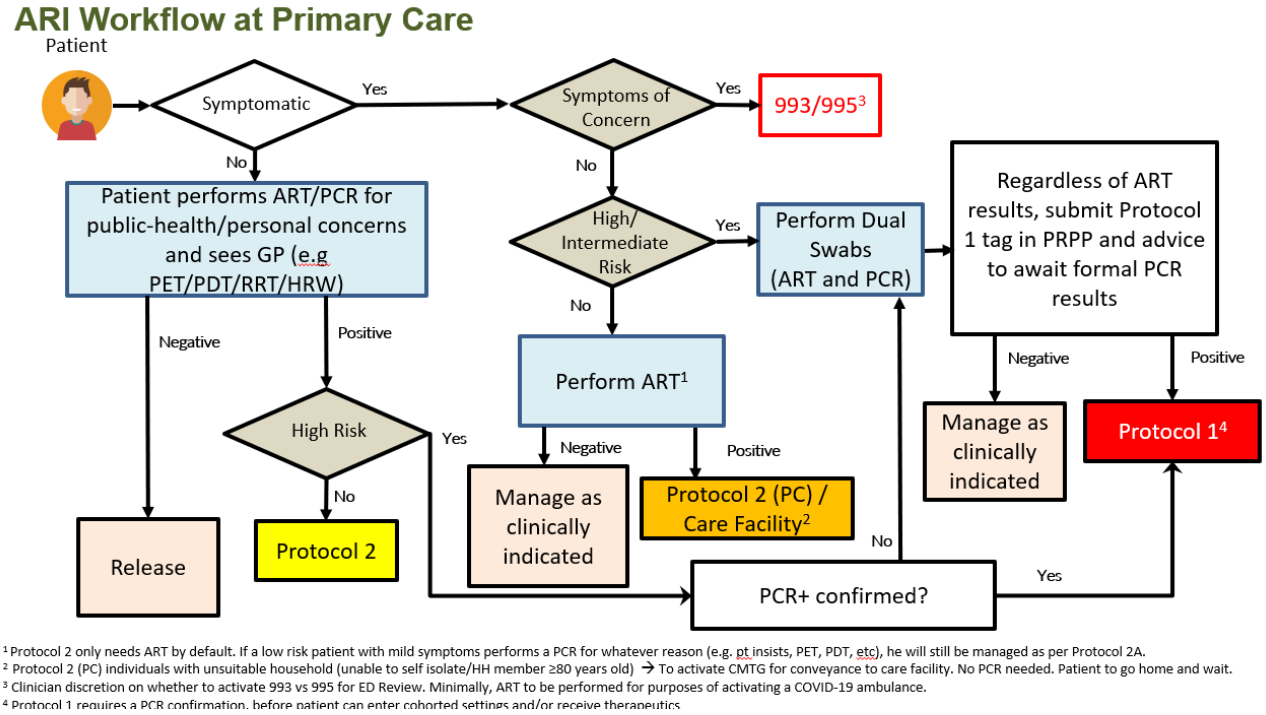
This COVID-19 clinical package aims to provide Primary Care Doctors with the relevant clinical and operational information needed to manage patients who present for either **acute respiratory infections (ARI) symptoms** OR for **COVID-19 tests**.

Appendices

B1. ARI Workflow and Decision Matrix for Primary Care Doctors
B2. Primary Care Doctor - COVID-19 Reference Script
B3. Information needed for CMTG to activate 993 / convey to Isolation Facility.

APPENDIX B1

ARI Workflow and Decision Matrix for Primary Care Doctors



[1] Protocol 2 only needs ART by default. If a low risk patient with mild symptoms performs a PCR for whatever reason (e.g. pt insists, PET, PDT, etc), he will still be managed as per Protocol 2A.
[2] Protocol 2 (PC) individuals with unsuitable household (unable to self isolate/HH member ≥80 years old) → To activate CMTG for conveyance to care facility. No PCR needed. Patient to go home and wait.
[3] Clinician discretion on whether to activate 993 vs 995 for ED Review. Minimally, ART to be performed for purposes of activating a COVID-19 ambulance.
[4] Protocol 1 requires a PCR confirmation, before patient can enter cohorted settings and/or receive therapeutics

Decision Matrix

	ARI Workflow		Asymptomatic Testing for Public Health Reasons (PDT/PET/RRT/HRW)
	Symptoms/Signs of Concern	**Mild Symptoms**	
High Risk patient	**Protocol 1** (Double Swabs – ART AND PCR)	**Protocol 1** (Double Swabs – ART AND PCR)	**Protocol 1** (Ensure confirmatory PCR swab performed if only ART+)
Intermediate Risk patient	**Protocol 1** (Double Swabs – ART AND PCR)	**Protocol 1** (Double Swabs – ART AND PCR)	**Protocol 2** (Either ART+ or PCR+)
Low Risk patient	**Protocol 1** (Double Swabs – ART AND PCR)	**Protocol 2 (Primary Care)** (Only ART+ needed)	**Protocol 2** (Either ART+ or PCR+)

* Refer to tables below for screening criteria for Adult and Paeds respectively

ADULT (≥12 years old) Risk Criteria

- **High Risk – Not Suitable for recovery at home**
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    - Disease or medications that suppress immune system
    - Advanced/untreated HIV or AIDS
    - ESRF on dialysis
    - Chronic organ disease at high risk of deterioration e.g Decompensated Congestive Heart failure, Liver failure, COPD
- **Intermediate Risk – Benefit from closer monitoring under HRP-Enhanced**
  - Obesity: (BMI >35 or Weight >100kg)
  - Poorly Controlled DM
  - Pregnant
  - Vaccinated 70-79 years old

ADULT Symptoms/Signs of Concern

- **Symptoms**
  - Shortness of breath
  - Chest pain
  - Acute stroke symptoms
  - Chest palpitations
  - Symptoms suggestive of DVT
  - Severe headache not better with pain meds
  - Persistent diarrhea/vomiting/unable to take in fluids
  - Persistent Fever ≥ 3 days (≥38 degrees Celsius)
- **Signs**
  - Tachycardia >100
  - Tachypnoea >20
  - Hypotension <100mmHg
  - SPO2 ≤ 94%

*Doctor to exercise clinical judgement on whether to activate 995 vs 993 (via CMTG)

PAEDS (<12 years old) Risk Criteria

- **High Risk – Not Suitable for recovery at home**
  - Prevailing Ineligible Criteria for Children
    - <3 months old
  - Comorbidities of Concern
    - Bone marrow/Organ transplant on immunosuppressant
    - Active/current cancer on chemotherapy/treatment
    - Leukemia/lymphoma/other heamotological malignancies
    - Disease or medications that suppress immune system
    - ESRF on dialysis
    - Poorly-controlled DM
    - Poorly-controlled HTN
    - Chronic/congenital respiratory conditions e.g. OSA, Chronic Lung Disease
    - Congenital heart/circulatory conditions
    - Neurodevelopmental conditions
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PAEDS Symptoms/Signs of Concern

- **Symptoms**
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  - Chest Palpitations
  - Drowsy/lethargic
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  - Prolonged Fever >38°C (continuously for 5 days or more)
  - Significant pain/discomfort anywhere
  - Headache worse than usual or not better with usual pain medications
  - Prolonged respiratory symptoms for 5 days or more
  - Persistent diarrhea/vomiting/abdominal pain and unable to take fluids (clinically unwell and fluid intake <50%)
  - Dehydrated - Poor urine output (<4 times/day)
  - Concerns of MIS-C/Kawasaki Disease
- **Signs**
  - SPO2 ≤ 94%
  - Tachycardia (Refer to table below)
  - Tachypnea (Refer to table below)

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3 months – < 6 months	80	160	30	60
6 months – <1 year	80	140	25	45
1 year – < 6 years	75	130	20	30
6 years – < 10 years	70	110	16	24
10 years – < 15 years	60	90	14	20
15 years and above	60	90	12	16

*Doctor to exercise clinical judgement on whether to activate 995 vs 993 (via CMTG)

TMARS link for P2PC patients (to request for TM provider): **go.gov.sg/telemedicineproviders**
Hotline for patients/public regarding P2PC (for non-medical queries): **6916 0190**
Hotline for Doctors regarding P2PC: **6916 0193**
CMTG Hotline (to request for 993 / arrange for conveyance to Isolation Facility): **64354060**
CMTG email: CMTG_call_centre@moh.gov.sg

APPENDIX B2
PRIMARY CARE DOCTOR - COVID-19 REFERENCE SCRIPT

GENERAL GUIDE AND INSTRUCTIONS FOR USAGE

This script serves as a possible template for the doctor in managing patients who present in a primary care setting. It is not meant to replace clinical judgement and acumen, especially if the clinical assessment is that the patient is deemed at higher risk than what is articulated in this script/clinical guideline. This script serves as a possible guide on management of patients who present for either **acute respiratory infections (ARI) symptoms** OR for **COVID-19 tests**.

This Script has **6 Sections** that are designed to flow naturally based on the consult's conversation:

A. Start of Script - Introduction
B. Adult (≥12 years old) Medical Screen
C. Paeds (<12 years old) Medical Screen
D. Way Ahead – Protocol 1
E. Way Ahead – Protocol 2 (Primary Care) **(P2PC)**
F. Way Ahead – Protocol 2

A. START OF SCRIPT- INTRODUCTION

Hi Mr/Ms **(Name of Patient)**, I am **DOCTOR (Name of Doctor).** I understand that you are here because you have ARI symptoms / would like to undergo a COVID-19 test

In line with MOH's latest guidelines, I will need to first assess you on your health status before advising you on the way ahead.

[If patient is **≥12 years old**]
➔ Proceed to **'B. ADULT (≥12 YEARS OLD) MEDICAL SCREEN'**

[If patient is <**12 years old**]
➔ Proceed to **'C. PAEDS (<12 YEARS OLD) MEDICAL SCREEN'**

B. ADULT (≥12 YEARS OLD) MEDICAL SCREEN

[If patient is **Symptomatic**]
➔ Proceed to **'B1. Medical Screen for Patients presenting with ARI symptoms'**

[If patient is **Asymptomatic**]
➔ Proceed to **'B2. Medical Screen for Asymptomatic Patients undergoing COVID-19 Tests'**

B1. Medical Screen for ADULT Patients Presenting with ARI symptoms

1. Do you have any of the following **symptoms/signs of concern** listed in Table 1 below?
   - If patient has ANY of the listed symptoms/signs, to activate either 993/995.
   - To consider performing ART swab→does not change clinical management but would impact choice of conveyance if COVID-19 positive. To inform call operator if test positive.
   - The following list is non-exhaustive and clinicians are recommended to activate 993/995 based on their clinical assessment as necessary

- Clinician to exercise judgment on whether 993 (via CMTG) or 995 will be more appropriate.

Table 1: Symptoms/Signs of Concern

Symptoms/Signs of Concern	
Symptoms	• Shortness of breath • Chest pain • Acute stroke symptoms • Chest palpitations • Symptoms suggestive of DVT • Severe headache not better with pain medications • Persistent diarrhea/vomiting/unable to take fluids • Persistent fever ≥5 days (≥38 degrees Celsius)
Signs	• Tachycardia > 100 • Tachypnoea > 20 • Hypotension <100mmHg • $SpO_2 \leq 94\%$

2. How old are you? What is your vaccination status?
    - If vaccinated ≥80YO or unvaccinated ≥50YO →not suitable for P2PC→ for Protocol 1

3. Have you (the patient) received any **organ or bone marrow transplant**?
    - *All organ or bone marrow transplant recipient (except cornea), will be taking some sort of immune-suppressing medications. Skin Grafts, Auto/Re-implantation that do not require immunosuppressants are not considered immunocompromised*
    - If yes: immunocompromised → not suitable for P2PC→ for Protocol 1

4. Do you (the patient) have any **active/ current cancer**?
    - If yes: Have you/ your family recovered from it?
    - If no: Are you/your family still on chemotherapy or medicines that weaken the immune system?
    - *Such chemotherapy drugs can be intravenous and given in 'cycles' or oral antibody therapy; however hormonal therapy for breast/ prostate cancers do not weaken the immune system.*
    - If yes (on active chemo/recent surgery): immunocompromised → not suitable for P2PC→ for Protocol 1

5. Do you (the patient) have any **active/current blood or lymph node cancers**?
    - *Such as leukemia, myeloma, lymphoma or other haematological cancers*
    - If yes: immunocompromised → not suitable for P2PC→ for Protocol 1

6. Do you have any disease or are you on any medications that suppress the immune system?
    - *Examples of diseases which suppress the immune system, organ transplantation. Common drugs which suppress the immune system include: steroids like prednisolone, and other drugs for autoimmune diseases/used to blunt the immune system e.g. methotrexate, mycophenolate, tacrolimus, cyclosporine, sirolimus, rituximab, etanercept etc.*
    - If yes: immunocompromised → not suitable for P2PC→ for Protocol 1

7. Do you have kidney failure on **dialysis**?

- End-stage kidney disease (i.e. on haemodialysis – typically patients go and "wash their blood" (blood dialysis) three times a week at a dialysis center, or peritoneal dialysis "wash the waste from their blood by putting dialysis fluid into their abdomen" – usually done at home)
- If yes → not suitable for P2PC→ for Protocol 1

8. Comorbidity of Concern 6: Do you have **advanced or untreated HIV**? Or AIDS? (To ask sensitively)
    - If yes → not suitable for P2PC→ for Protocol 1

9. Comorbidity of Concern 7: Do you have any serious problems/major diseases which may affect your **heart, lung, liver, or brain/nerves at high risk of deterioration**?
    - Surrogate question: Do you have a very weak heart /heart failure (e.g. decompensated heart failure), or poor lungs (e.g. COPD, bronchiectasis), or a bad liver / liver failure, or a disease affecting your brain or nerves (e.g. you cannot walk), AND **was admitted to hospital for this condition once or more in the last 6 months**?
    - If yes to any of above, the condition is high risk for deterioration→ not suitable for P2PC→ for Protocol 1 and will require PCR, for Protocol 1

10. Do you have **Poorly controlled diabetes**?
    - To assess if diabetes is poorly controlled, including incidents of hypo/hyperglycaemia, hyperglycaemic crisis, poor HbA1c.
    - To assess for worsening complications of Diabetes, including retinopathy, vasculopathy, neuropathy, frequent infections.
    - If yes: poorly-controlled or has complicated DM→ not suitable for P2PC→ for Protocol 1

11. How heavy are you? (assess for obesity)
    - If >100kg or BMI>35 → not suitable for P2PC→ for Protocol 1

12. Are you **pregnant**?
    - If yes: pregnant → not suitable for P2PC→ for Protocol 1

[If yes to any of the above→ for Protocol 1]
➔ Proceed to **'D. Way Ahead – Protocol 1'**

[If No to ALL of the above→ for Protocol 2 (Primary Care)]
➔ Proceed to **'E. Way Ahead – Protocol 2 (Primary Care)'**

B2. Medical Screen for Asymptomatic ADULT Patients undergoing COVID-19 Tests

[If **only ART performed and negative**→ no further action]
-END-

[If **ART performed and positive** OR **PCR performed** → proceed with rest of medical screening to filter out **High Risk** patients]

1. How old are you? What is your vaccination status?
    - If vaccinated ≥**80YO**, unvaccinated ≥50YO → not suitable for Protocol 2→ for Protocol 1

2. Have you (the patient) received any **organ or bone marrow transplant**?
    - *All organ or bone marrow transplant recipient (except cornea), will be taking some sort of immune-suppressing medications. Skin Grafts, Auto/Re-implantation that do not require immunosuppressants are not considered immunocompromised*
    - If yes: immunocompromised → not suitable for Protocol 2→ for Protocol 1

3. Do you (the patient) have any **active/ current cancer**?
    - If yes: Have you/ your family recovered from it?
    - If no: Are you/your family still on chemotherapy or medicines that weaken the immune system?
    - *Such chemotherapy drugs can be intravenous and given in 'cycles' or oral antibody therapy; however hormonal therapy for breast/ prostate cancers do not weaken the immune system.*
    - If yes (on active chemo/recent surgery): immunocompromised → not suitable for Protocol 2→ for Protocol 1

4. Do you (the patient) have any **active/current blood or lymph node cancers**?
    - *Such as leukemia, myeloma, lymphoma or other haematological cancers*
    - If yes: immunocompromised → not suitable for Protocol 2→ for Protocol 1

5. Do you have any disease or are you on any medications that suppress the immune system?
    - *Examples of diseases which suppress the immune system, organ transplantation. Common drugs which suppress the immune system include: steroids like prednisolone, and other drugs for autoimmune diseases/used to blunt the immune system e.g. methotrexate, mycophenolate, tacrolimus, cyclosporine, sirolimus, rituximab, etanercept etc.*
    - If yes: immunocompromised → not suitable for Protocol 2→ for Protocol 1

6. Do you have kidney failure on **dialysis**?
    - End-stage kidney disease (i.e. on haemodialysis – typically patients go and "wash their blood" (blood dialysis) three times a week at a dialysis center, or peritoneal dialysis "wash the waste from their blood by putting dialysis fluid into their abdomen" – usually done at home)
    - If yes → not suitable for Protocol 2→ for Protocol 1

7. Comorbidity of Concern 6: Do you have **advanced or untreated HIV**? Or AIDS? (To ask sensitively)
    - If yes → not suitable for Protocol 2→ for Protocol 1

8. Comorbidity of Concern 7: Do you have any serious problems/major diseases which may affect your **heart, lung, liver, or brain/nerves at high risk of deterioration**?
    - Surrogate question: Do you have a very weak heart /heart failure (e.g. decompensated heart failure), or poor lungs (e.g. COPD, bronchiectasis), or a bad liver / liver failure, or a disease affecting your brain or nerves (e.g. you cannot walk), AND **was admitted to hospital for this condition once or more in the last 6 months**?
    - If yes to any of above, the condition is high risk for deterioration→ not suitable for Protocol 2→ for Protocol 1

[If yes to any of the above→ for Protocol 1]
Proceed to **'D. Way Ahead – Protocol 1'**

[If No to ALL of the above→ for Protocol 2]
Proceed to **'F. Way Ahead – Protocol 2'**

C. PAEDS (<12 YEARS OLD) MEDICAL SCREEN

[If patient is **Symptomatic**]
➔ Proceed to **'C1. Medical Screen for PAEDS Patients presenting with ARI symptoms'**

[If patient is **Asymptomatic**]
➔ Proceed to **'C2. Medical Screen for Asymptomatic PAEDS Patients undergoing COVID-19 Tests'**

C1. Medical Screen for PAEDS Patients Presenting with ARI symptoms

Does your child have any of these Emergency symptoms:

1. Is your child short of breath / breathless?
   i. If they have a pulse oximeter[4], can ask if they have checked and if the reading ≤ 94%
2. Does he/she have any chest pain or chest pressure?
3. Does your child feel that his/her heart is racing/beating very fast or he/she is breathing very fast?
4. Is your child drowsy or lethargic?
5. Where possible or if pulse oximeter present, ask them what their pulse rate is (>90 beats / minute for paediatric population is fast – refer to table below)
6. Where possible, ask them what their breathing rate is (RR for paediatric population is age-dependent, kindly refer to table below)
7. Assess for Tachypnoea/Wheezing/Respiratory distress.

AGE	HEART RATE		RESPIRATORY RATE	
	Minimum	Maximum	Minimum	Maximum
Birth – < 3 months	90	180	30	60
3 months – < 6 months	80	160	30	60
6 months – <1 year	80	140	25	45
1 year – < 6 years	75	130	20	30
6 years – < 10 years	70	110	16	24
10 years – < 15 years	60	90	14	20
15 years and above	60	90	12	16

8. Suspicion of MIS-C (as per table below)

[4] For children less than 7 years of age, depending on probe used, SpO2 shown may not be truly reflective of actual SpO2. To assess in conjunction with clinical assessment of patient.

Criteria for case definition of MIS-C

- **All 6 criteria must be fulfilled to meet case definition.**
- However, due to limitations of TM assessment, patients should be conveyed to hospital ED for further evaluation if there is clinical suspicion.

1) Age 0-19YO
2) Persistent high fever (>38.5°C) for 3 or more days
3) Signs of multisystem involvement (at least 2 systems below)
    a. Cardiovascular (e.g. raised cardiac biomarkers, pericarditis, coronary abnormalities, ECG abnormalities)
    b. Hypotension or shock (e.g. light-headedness/dizziness)
    c. Gastrointestinal (e.g. diarrhea, vomiting, abdominal pain)
    d. Mucocutaneous features (e.g. rash, conjunctivitis, mucositis/red, cracked lips and red tongue, swollen hands or feet)
    e. Neurological manifestations (e.g. headache, altered mental state, seizures)
    f. Haemotological (e.g. lymphopenia, thrombocytopenia, coagulopathy)
    g. Respiratory (e.g. shortness of breath, tachypnoea)
    h. Renal (e.g. marks of acute renal injury)
4) Elevated markers of inflammation (e.g. CRP, ferritin, Procalcitonin, fibrinogen)
5) Other bacterial/viral causes are excluded AND
6) Evidence of current or recent COVID infection (e.g. PCR-positive, serology positive or antigen positive)

Notes for MIS-C:

- Always have a **high index of suspicion** for children **displaying high fever (>38.5°C) for 3 or more days at presentation and fulfilling 2 or more of the signs of multisystem involvement**, in **confirmed COVID-19 paediatric cases** and **paediatric cases who have recently recovered from COVID-19 infection (within 2 to 8 weeks prior to clinical presentation of MIS-C manifestations)**
- There is significant overlap in the presentations of MIS-C and Kawasaki. Even in the known diagnosis or clinical suspicion of Kawasaki, the recommendation is to still convey these patients to ED for review.

- If Yes to any emergency symptoms, call 995 and request for an ambulance.

9. Other Symptoms of concern

i. Does your child have a fever of >40°C (hyperpyrexia)?
ii. Has your child had a fever >38°C continuously for ≥5 days?
    - Note that this fever cut off is a **contraindication for home recovery by its own**. Whereas, the fever cut-off for MIS-C (of >38.5 for ≥3 days) is part of a larger criteria that must be fulfilled before the child should be deemed to meet MIS-C case criteria.
iii. Any significant pain/discomfort anywhere?
iv. Headache that is worse than normal or not better with usual pain medications
v. Prolonged Respiratory symptoms >5 days
vi. Persistent diarrhoea / vomiting / abdominal pain and unable to take fluids (clinically unwell and fluid intake less than 50% of usual)
vii. Poor urine output (<4 times/day)
viii. Any other clinical concerns that might warrant an admission to **Hospital/evaluation at ED**

- If patient has ANY of the listed symptoms/signs, to activate either 993/995 (depending on clinical discretion)
- ED will thereafter assess and decide if patient should be admitted / divert to another care facility / discharged.

10. How old are you?
    - If < 5 years old→ not suitable for P2PC→ for Protocol 1

11. Comorbidity of Concern 1: Has your child received any organ or bone marrow transplant?
    - *(Note: All organ or bone marrow transplant recipient (except cornea), will be taking some sort of immune-suppressing medications. Skin Grafts, Auto/Re-implantation that do not require immunosuppressants are not considered immunocompromised)*
    - If yes: immunocompromised → not suitable for P2PC→ for Protocol 1

12. Comorbidity of Concern 2: Does your child have any active/ current cancer?
    - If yes: Has your child recovered from it? – If recovered proceed to question 8.
    - If no: Is your child still on chemotherapy or medicines that weaken the immune system?
    - (Note: Such chemotherapy drugs can be intravenous and given in 'cycles' or oral antibody therapy; however hormonal therapy for breast/ prostate cancers do not weaken the immune system)
    - If yes (still on active chemotherapy/surgery): immunocompromised → not suitable for P2PC→ for Protocol 1

13. Comorbidity of Concern 3: Does your child have any active/current blood or lymph node cancers?
    - (Note: such as leukemia, myeloma or lymphoma)
    - If yes: immunocompromised → not suitable for P2PC→ for Protocol 1

14. Comorbidity of Concern 4: Does your child have any disease or is on any medications that suppress the immune system?
    - (Note: Examples of diseases which suppress the immune system, organ transplantation. Common drugs which suppress the immune system include: steroids like prednisolone, and other drugs for autoimmune diseases/used to blunt the immune system e.g. methotrexate, mycophenolate, tacrolimus, cyclosporine, sirolimus, rituximab, etanercept etc)
    - If yes: immunocompromised → not suitable for P2PC→ for Protocol 1

15. Comorbidity of Concern 5: Does your child have kidney failure on dialysis?
    - Note: End-stage kidney disease (i.e. on haemodialysis – typically patients go and "wash their blood" (blood dialysis) three times a week at a dialysis center, or peritoneal dialysis "wash the waste from their blood by putting dialysis fluid into their abdomen" – usually done at home)?
    - If yes: not suitable for P2PC→ for Protocol 1

16. Comorbidity of Concern 6: Does your child have diabetes?
    - To assess if diabetes is poorly controlled, including incidents of hypo/hyperglycaemia, hyperglycaemic crisis
    - To assess for complications of Diabetes, including retinopathy, vasculopathy, neuropathy, frequent infections.
    - If yes: not suitable for P2PC→ for Protocol 1

17. Comorbidity of Concern 7: Does your child have high blood pressure?
    - To assess for poorly controlled hypertension, including episodes of hypertensive urgencies/emergencies, persistent high blood pressure and recent/frequent change in medications.
    - If yes: not suitable for P2PC→ for Protocol 1

18. Comorbidity of Concern 8: Does your child have any chronic or congenital respiratory conditions? E.g. Asthma, Chronic Lung Disease, Obstructive Sleep Apnea

- To assess if poorly controlled asthma (including frequency of attacks, use of controllers), admissions into hospitals, effort tolerance and presence of wheeze/tachyponea/respiratory distress during tele-consult.
- If poorly controlled or high risk of deterioration: not suitable for P2PC→ for Protocol 1

19. Comorbidity of Concern 9: Does your child have any congenital heart or circulatory conditions? In other words, any heart/circulatory conditions since birth?

- To assess for type and stability of congenital condition, including whether the condition has been treated/operated vs progressive
- Specific groups of concern highlighted by the AHA and British Congenital Cardiac Association[5]:
  i. Single ventricle patients status post Fontan Operation
  ii. Patients with chronic cyanosis (SpO2 <85%)
  iii. Severe cardiomyopathy requiring medications or depressed cardiac function in congenital patients
  iv. Severe pulmonary hypertension
  v. Post heart transplantation
  vi. Infants with unrepaired congenital heart disease e.g. Tetralogy of Fallot, VSD/ASD
  vii. Pre-existing non-cardiac conditions and syndromes that may result in reduced immunity
- To also assess whether there were recent admissions due to this cardiac condition.
- If any of the above present: not suitable for P2PC→ for Protocol 1

20. Comorbidity of Concern 10: Does your child have any neurodevelopmental conditions?

- To establish diagnosis and stability of condition---assess if severe and/or progressive
- To assess on presence of complications of the condition and whether the patient is at risk of deterioration due to COVID-19.
- To also assess on whether child needs special nursing care – ADL assisted/dependent, difficulty eliciting symptoms or monitoring for deterioration
- If any of the above present: not suitable for P2PC→ for Protocol 1

21. Is your child obese? (To obtain height and weight. Obesity = BMI≥27.5)

- Obese children who are otherwise healthy, can be enrolled onto P2PC if counselled properly and given follow up consults.
- If morbidly obese or if any other medical conditions (not amounting to the above comorbidity of concerns) are present→ not suitable for P2PC→ for Protocol 1

[If yes to any of the above→ for Protocol 1]
➔ Proceed to **'D. Way Ahead – Protocol 1'**

[If No to ALL of the above→ for Protocol 2 (Primary Care)]
➔ Proceed to **'E. Way Ahead – Protocol 2 (Primary Care)'**

[5] Coronavirus Disease 2019 (COVID-19) Pandemic Implications in Pediatric and Adult Congenital Heart Disease. (2021). Retrieved 11 November 2021, from https://www.ahajournals.org/doi/abs/10.1161/JAHA.120.017224

C2. Medical Screen for Asymptomatic PAEDS Patients undergoing COVID-19 Tests

[If **only ART performed and negative** → no further action]
-END-

[If **ART performed and positive** OR **PCR performed** → proceed with rest of medical screening to filter out **High Risk** patients]

1. How old are you?
   - If < 3 months old → not suitable for Protocol 2 → for Protocol 1

2. Comorbidity of Concern 1: Has your child received any organ or bone marrow transplant?
   - *(Note: All organ or bone marrow transplant recipient (except cornea), will be taking some sort of immune-suppressing medications. Skin Grafts, Auto/Re-implantation that do not require immunosuppressants are not considered immunocompromised)*
   - If yes: immunocompromised → not suitable for Protocol 2 → for Protocol 1

3. Comorbidity of Concern 2: Does your child have any active/ current cancer?
   - If yes: Has your child recovered from it? – If recovered proceed to question 8.
   - If no: Is your child still on chemotherapy or medicines that weaken the immune system?
   - (Note: Such chemotherapy drugs can be intravenous and given in 'cycles' or oral antibody therapy; however hormonal therapy for breast/ prostate cancers do not weaken the immune system)
   - If yes (still on active chemotherapy/surgery): immunocompromised → not suitable for Protocol 2 → for Protocol 1

4. Comorbidity of Concern 3: Does your child have any active/current blood or lymph node cancers?
   - (Note: such as leukemia, myeloma or lymphoma)
   - If yes: immunocompromised → not suitable for Protocol 2 → for Protocol 1

5. Comorbidity of Concern 4: Does your child have any disease or is on any medications that suppress the immune system?
   - (Note: Examples of diseases which suppress the immune system, organ transplantation. Common drugs which suppress the immune system include: steroids like prednisolone, and other drugs for autoimmune diseases/used to blunt the immune system e.g. methotrexate, mycophenolate, tacrolimus, cyclosporine, sirolimus, rituximab, etanercept etc)
   - If yes: immunocompromised → not suitable for Protocol 2 → for Protocol 1

6. Comorbidity of Concern 5: Does your child have kidney failure on dialysis?
   - Note: End-stage kidney disease (i.e. on haemodialysis – typically patients go and "wash their blood" (blood dialysis) three times a week at a dialysis center, or peritoneal dialysis "wash the waste from their blood by putting dialysis fluid into their abdomen" – usually done at home)?
   - If yes: not suitable for Protocol 2 → for Protocol 1

7. Comorbidity of Concern 6: Does your child have diabetes?

- To assess if diabetes is poorly controlled, including incidents of hypo/hyperglycaemia, hyperglycaemic crisis
- To assess for complications of Diabetes, including retinopathy, vasculopathy, neuropathy, frequent infections.
- If yes: not suitable for Protocol 2 → for Protocol 1

8. Comorbidity of Concern 7: Does your child have high blood pressure?
    - To assess for poorly controlled hypertension, including episodes of hypertensive urgencies/emergencies, persistent high blood pressure and recent/frequent change in medications.
    - If yes: not suitable for Protocol 2 → for Protocol 1

9. Comorbidity of Concern 8: Does your child have any chronic or congenital respiratory conditions? E.g. Asthma, Chronic Lung Disease, Obstructive Sleep Apnea
    - To assess if poorly controlled asthma (including frequency of attacks, use of controllers), admissions into hospitals, effort tolerance and presence of wheeze/tachyponea/respiratory distress during tele-consult.
    - If poorly controlled or high risk of deterioration: not suitable for Protocol 2 → for Protocol 1

10. Comorbidity of Concern 9: Does your child have any congenital heart or circulatory conditions? In other words, any heart/circulatory conditions since birth?
    - To assess for type and stability of congenital condition, including whether the condition has been treated/operated vs progressive
    - Specific groups of concern highlighted by the AHA and British Congenital Cardiac Association[6]:
        i. Single ventricle patients status post Fontan Operation
        ii. Patients with chronic cyanosis (SpO2 <85%)
        iii. Severe cardiomyopathy requiring medications or depressed cardiac function in congenital patients
        iv. Severe pulmonary hypertension
        v. Post heart transplantation
        vi. Infants with unrepaired congenital heart disease e.g. Tetralogy of Fallot, VSD/ASD
        vii. Pre-existing non-cardiac conditions and syndromes that may result in reduced immunity
    - To also assess whether there were recent admissions due to this cardiac condition.
    - If any of the above present: not suitable for Protocol 2 → for Protocol 1

11. Comorbidity of Concern 10: Does your child have any neurodevelopmental conditions?
    - To establish diagnosis and stability of condition---assess if severe and/or progressive
    - To assess on presence of complications of the condition and whether the patient is at risk of deterioration due to COVID-19.
    - To also assess on whether child needs special nursing care – ADL assisted/dependent, difficulty eliciting symptoms or monitoring for deterioration
    - If any of the above present: not suitable for Protocol 2 → for Protocol 1

[If yes to any of the above→ for Protocol 1]
Proceed to **'D. Way Ahead – Protocol 1'**

[6] Coronavirus Disease 2019 (COVID-19) Pandemic Implications in Pediatric and Adult Congenital Heart Disease. (2021). Retrieved 11 November 2021, from https://www.ahajournals.org/doi/abs/10.1161/JAHA.120.017224

[If No to ALL of the above→ for Protocol 2]
Proceed to **'F. Way Ahead – Protocol 2'**

D. WAY AHEAD – PROTOCOL 1

Sir/Mdm, I will proceed to perform both an ART (if not done) AND PCR swab for you. If your PCR swab turns out positive, you will receive an SMS for fill up a FormSG.

For now, I will be issuing you with a MC while you await your PCR swab test results.

During the period of your MC, you are advised to self-isolate as much as possible and to only leave your place of residence when necessary. Do also minimize social interaction with others whilst awaiting your PCR swab test results.

In the event of medical emergency which include chest pain, difficulty breathing, or pulse oximeter showing 92% or less, please **call 995 immediately.**

If you require any further medical attention whilst awaiting your swab results, you may return to see me.

[Perform DUAL SWABS – ART AND PCR (if not done)]

[For PRPP/iConnect: Click 'Protocol 1' Indicator]

-END-

E. WAY AHEAD – PROTOCOL 2 (PRIMARY CARE)

My assessment is that based on the new MOH protocols, all you need is an ART test.

[PERFORM ART]

[If **ART negative and patient accepts results**→ **No further action required**. Manage as clinically indicated.]
-END-

[If **ART negative but patient insists on performing a PCR** → Reassure patient that PCR not needed and explain that if PCR turns positive (<3% chance), patient will still be managed as per protocol 2.

→If still insist, proceed to '**E1. IF LOW-RISK ART-NEGATIVE PATIENT INSISTS ON PCR**]

[If **ART positive** → proceed with below]

Your ART result is positive, confirming that you are COVID-19 positive.

You are required to isolate for a minimum of 72 hours from today. After 72 hours, you must perform a self-administered ART and it must be negative before you can exit self-isolation. If you are still symptomatic or if the ART result is positive, please continue to isolate yourself at home.

You are to self-isolate until your ART is negative or until 12 noon on D7 (for fully vaccinated individuals and children below 12 years old) or D14 (for unvaccinated / partially vaccinated individuals aged 12 years old and above), whichever is earlier. Today/The date of your ART test is taken as D1.

Meanwhile, please isolate at home and minimize social interaction with others. You are only allowed leave your place of isolation essential activities- such as to obtain necessities for daily living or to visit the doctor.

I will be issuing you with a **5 day** MC (minimum 5 days, but duration of MC up to discretion of clinician) to cover you while you recover from your symptoms and in case your ART takes a while to turn negative.

You will also receive an SMS to fill up a FormSG. Please fill up the names and details of your household members as they will be issued with a Health Risk Warning.

In the event of medical emergency which include chest pain, difficulty breathing, or pulse oximeter showing 92% or less, please **call 995 immediately.**

If you require further medical attention after today's consult, feel free to return back to see me. You may also contact my clinic at _____(clinic telephone number).

If you require any medical attention after office hours (if clinic is not open 24/7), you may go to **go.gov.sg/telemedicineproviders** to get in touch with a Telemedicine provider for after-hours consultations.

[For PRPP/iConnect: Click 'Protocol 2 (Primary Care)' Indicator]

[If **ART positive and patient accepts above management→End consult**.]

-END-

If **ART positive and patient insists on PCR**→Proceed to **'D2. IF PROTOCOL 2 (PRIMARY CARE) ART-POSITIVE PATIENT INSISTS ON PCR'**]

If **ART positive and patient insists cannot isolate at home**→Proceed to **'D3. IF ART-POSITIVE PATIENT INSISTS ON GOING TO ISOLATION FACILITY**]

E1. IF LOW-RISK ART-NEGATIVE PATIENT INSISTS ON PCR

Based on MOH protocols, there is no need to perform a PCR, as it does not change management.

[Try to convince patient that PCR is not required. Clarify misconceptions if any- refer to FAQs]

Sir/Mdm, I would like to explain to you that even if the PCR turns out positive, your management will still be managed as per Protocol 2 (Primary Care). You will receive an SMS within the next 1-2 days to inform you of your PCR results.

If your PCR turns out as negative, you should still stay home until your symptoms resolve. As your PCR is negative, you can leave the house once you have recovered and there is no need for further ART tests.

[For PRPP/iConnect: Click 'Protocol 2 (Primary Care)' Indicator]

[PERFORM PCR]

-END-

E2. IF PROTOCOL 2 (PRIMARY CARE) ART-POSITIVE PATIENT INSISTS ON PCR

Based on MOH protocols, there is no need to perform a PCR, as it does not change management.

[Try to convince patient that PCR is not required. Clarify misconceptions if any- refer to FAQs]

Sir/Mdm, I would like to explain to you that even if the PCR turns out positive, your management will be as per what I have explained to you earlier and you will still be managed as per Protocol 2 (Primary Care). You will receive an SMS within the next 1-2 days to inform you of your PCR results.

If your PCR turns out as negative (<3% chance), you should still stay home until your symptoms resolve. As your PCR is negative, you can leave the house once you have recovered and there is no need for further ART tests.

[PERFORM PCR]

-END-

E3. IF PROTOCOL 2 (PRIMARY CARE) ART-POSITIVE PATIENT INSISTS ON GOING TO ISOLATION FACILITY

[Doctor to assess household risk]

1. Do you have any household member who is 80 years old or older?

2. Are you unable to self-Isolate at Home?

The following categories of household risks are deemed **BELOW THRESHOLD** (decision matrix approved by MOH):

1. Patient indicated **unable to self-isolate only (I.e. only one risk factor)**
2. Patient indicated **having a household member above 80 years old (I.e. only one risk factor)**
3. Patient indicated **BOTH [unable to self-isolate] AND [has an 80 year old who is VACCINATED AND HAS NO COMORBIDITIES OF CONCERN]**

- If patient is below threshold→reassure and explain patient is to isolate at home and minimize interaction with others.

The following categories of household risks are deemed **ABOVE THRESHOLD:**

1. Patient indicated **BOTH [unable to self-isolate] AND [has an 80 year old who is UNVACCINATED]**
2. Patient indicated **BOTH [unable to self-isolate] AND [has an 80 year old who has COMORBIDITIES OF CONCERN]**

- If patient is above threshold and insists on isolating in a government isolation facility→ proceed to arrange for conveyance to an isolation facility (CMTG to decide on isolation facility). Collect patient information as per Appendix A2 to pass on to CMTG. Instruct patient to proceed directly home and isolate while awaiting MOH conveyance.

[Call CMTG to arrange for conveyance to Isolation Facility]

-END-

F. WAY AHEAD – PROTOCOL 2

Sir/Mdm, I will proceed to perform an ART/PCR swab for you. If your results come out positive, you are to follow Protocol 2.

You are required to isolate for a minimum of 72 hours from the date of your positive test result. After 72 hours, you must perform a self-administered ART and it must be negative before you are to leave home.

If your repeat ART result is positive, you are to continue isolating at home and minimize social interaction with others. You are only allowed leave your place of isolation essential activities- such as to obtain necessities for daily living or to visit the doctor.

You are to self-isolate until your ART is negative or until 12 noon on D7 (for fully vaccinated individuals and children below 12 years old) or D14 (for unvaccinated / partially vaccinated individuals aged 12 years old and above). Today/The date of your ART test is taken as D1.

If you feel unwell or require further medical attention after today's consult, feel free to return back to see me. You may also contact my clinic at _____(clinic telephone number).

In the event of medical emergency which include chest pain, difficulty breathing, or pulse oximeter showing 92% or less, please **call 995 immediately.**

[For PRPP/iConnect: Click 'Protocol 2' Indicator]

[PERFORM ART / PCR as indicated]

-END-

Appendix B3

Information needed for CMTG to activate 993 / convey to Isolation Facility.

S/N	Details needed	Remarks
1	Patient full name (as per NRIC)	-
2	Patient's NRIC/ FIN	Passport number (if foreigner)
3	Patient's Date of Birth (Age)	Affects triage criteria and only certain facilities handle certain age groups (e.g. paeds or elderly)
4	Pass type	SCPR/WP/DP/EP/Spass
5	Sex	Potentially affects room allocation for facilities.
6	Is patient pregnant?	Only certain hospitals/facilities manage pregnant women
7	Is patient on dialysis? Haemodialysis or Peritoneal dialysis?	Dialysis patients should be onboarded onto Protocol 1
8	Healthcare Protocol status	Protocol 1 vs P2PC (Patient should not be on protocol 2)
9	Symptoms (Please describe briefly)	• **Emergent symptoms** (chest pain/SOB/Stroke /Palpitations)- please call 995 • **Semi-urgent symptoms** (prolonged fever / severe headache / DVT symptoms etc) – 993 for ED review • **ARI symptoms** (cough, sore throat, runny nose) – relevant for conveyance to isolation facility only
10	Reason for Conveyance Request	• Request for 993 ambulance to convey to ED, or • Request for non-urgent conveyance to isolation facility, as patient unable to isolate at home
11	Patient's address	Patient can be sent home first, and CMTG will pick patient up from their residence. Should the patient ask to be picked up from the clinic, please specify so.
12	Patient's contact number	Handphone & Home Phone number
13	Clinic address	Patient can be sent home first, and CMTG will pick patient up from their residence. Should the patient ask to be picked up from the clinic, please specify so.
14	Clinic Phone Number	To provide a POC and number that can be contacted 24/7 in event clinic only opens during office-hours.

CMTG Hotline: **64354060** (Always call CMTG to request for conveyance)
CMTG email: CMTG_call_centre@moh.gov.sg

Annex C

CONDITIONS THAT WOULD BENEFIT FROM FURTHER CLINICAL ASSESSMENT

1. Individuals with the following conditions are potentially at-risk and should visit a doctor after testing positive for COVID-19, even if they are feeling well:

   a. Fully vaccinated and aged 70 years and above;

   b. Unvaccinated/partially vaccinated and aged 50 years and above;

   c. Aged 5 years and below;

   d. Had an organ transplant surgery in the past;

   e. Have any disease or are taking any medication that weakens the immune system;

   f. Have been diagnosed with cancer (including blood cancers) before;

   g. Are on dialysis;

   h. Are diagnosed with HIV or AIDS;

   i. Have a disease affecting your heart, lungs, kidneys, liver, or brain that required hospital admission in the last 6 months;

   j. Are pregnant;

   k. Are less than 12 years old and have any congenital condition or growth disorder that affects the heart, lungs or brain; or

   l. Are less than 12 years old and have Diabetes Mellitus or hypertension.

2. The doctor will clinically assess the health status and severity of their symptoms of these individuals. Individuals may still be deemed suitable for recovery at home (either under the doctor's direct care (P2PC) or under MOH's Home Recovery Programme) OR be conveyed to a care facility for closer monitoring and/or therapeutics.

Annex G

PATIENTS' JOURNEYS

Level of care	Previous Measures	With Immediate Effect: Align P1 de-isolation to P2 regime
P1 : Hospital / CTF	• No IO issued on admission • If patient decanted to CTF or HRP (Enhanced) before D10 (fully vaccinated and children <12yo) or D14 (unvaccinated/ partially unvaccinated) →IO will be issued for remaining days (D1 taken as date of first positive test) • DM issuance on D9 / D13 • TT turn to red for duration of IO	• If patient deemed clinically suitable* for discharge by doctors after >72 hours and ART swab negative → no further isolation needed. MC issued as clinically indicated • If patient decanted to CTF or HRP (Enhanced) before 72H→ MC will be issued. Self-exit via negative self-administered ART after 72H OR until time-based discharge at 12 noon on D7 (fully vaccinated and children <12yo) or D14 (unvaccinated/partially vaccinated), whichever is earlier • 3 x ART kit via vending machine • Recovery Memo to be issued on D7 (fully vaccinated and children <12yo) or D14 (unvaccinated/partially vaccinated) • TT remains grey
P1 : CIF	• IO issued for D10 (fully vaccinated and children <12 yo) or D14 (unvaccinated/partially vaccinated) • DM issuance on exit • If patient decanted to HRP Enhanced before D10 (fully vaccinated and children <12yo) or D14 (unvaccinated/ partially vaccinated)→ serve remaining days of IO at home • TT turn to red for duration of IO	

P1 : HRP	• IO issued for D10 (fully vaccinated and children <12 yo) or D14 (unvaccinated/partially vaccinated) • DM issuance on D9 / D13 • TT turn to red for duration of IO • TM Review	• Self-exit via self-administered negative ART after 72H OR until time-based discharge at 12vnoon on D7 (fully vaccinated or children <12 yo) or D14 (unvaccinated/ partially vaccinated), whichever is earlier • Recovery Memo to be issued on D7 (fully vaccinated and children <12yo) or D14 (unvaccinated/partially vaccinated) • 3 x ART kit • TM Review (if assessed as necessary) • TT remains grey
P2PC	• 5D MC will be issued. • Self-exit via a negative self-administered ART after 72H **OR** until time-based discharge at 12noon on D10 (fully vaccinated or children <12 yo) or D14 (unvaccinated/partially vaccinated), whichever is earlier • 6 x ART kit via vending machine • TT Grey • Recovery Memo on request by GP • Access to TM • Previously, only vaccinated individuals aged 12-69 years old and unvaccinated individuals aged 12-49 years old were eligible for P2PC	• 5D MC will be issued (no legal obligation for staying home) • Self-exit via a negative self-administered ART after 72H **OR** until time-based discharge at 12noon on D7 (Fully vaccinated) or D14 (unvaccinated or partially vaccinated), whichever is earlier • 3 x ART kit via vending machine • TT remains grey • Recovery Memo on request by GP • Access to TM • Children aged 5-11 years old (regardless of vaccination status) are now also eligible for P2PC, on top of vaccinated individuals aged 12-69 years old and unvaccinated individuals aged 12-49 years old
P2	• No change	

* Clinically suitable = afebrile, resolving symptoms and clinically improving

Annex H

REVISION OF HEALTHCARE PROTOCOLS
FREQUENTLY ASKED QUESTIONS (FAQs)
(Information Accurate as of 21 Jan 2022)

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Summary points:

- From 6 January 2022, both Antigen Rapid Test (ART) & Polymerase Chain Reaction (PCR) swabs will be accepted test modalities in the diagnosis of COVID-19.

- Patients should be triaged to Protocol 1, Protocol 2 (Primary Care) and 2 based on the severity of their symptoms and/or risk factors.
  - **Protocol 1:** Patients who are high risk and/or have symptoms/signs of concern. Please perform dual swabs (ART and PCR tests) for such patients.
  - **Protocol 2 (Primary Care):** Low-risk patients with mild symptoms. Please provide a healthcare-administered ART swab as the default.
  - **Protocol 2:** Low risk patients with no symptoms will continue to be managed as per current Protocol 2. Please submit the Protocol tag for such persons as Protocol 2, unless they are high risk. High risk persons should be tagged as "Protocol 1".

- Patients under Protocol 1 and Protocol 2 (Primary Care) will be accorded recovered status (e.g. eligible for Vaccination-Differentiated Safe Management Measures (VDS) Pre-Event Testing (PET) exemptions) based on prevailing policy when the recovery protocol is completed, i.e., 7 days (for fully vaccinated individuals and children below 12 years old) or 14 days (for unvaccinated/partially vaccinated individuals aged 12 years old and above).

- Please note the management approach for Protocol 2 (Primary Care)
  - Exit self-isolation any time after 72 hours after self-testing ART negative (i.e. from Day 4 onwards, where Day 1 is day of healthcare-administered test result) or until 12 noon of Day 7 (for fully vaccinated individuals and children below 12 years old) or Day 14 ((for unvaccinated/partially vaccinated individuals aged 12 years old and above) whichever is earlier.
  - Please issue a 5-day MC to cover the estimated period of rest needed and to minimize the need for return visits to extend MC.
  - Patients may return to their doctor if they face concerns, with prevailing subsidies (including special flu subsidies if eligible) to apply.
  - No recovery memo will be issued automatically; clinics may choose to provide a recovery memo at own discretion.
  - For queries by persons on Protocol 2 (Primary Care), please direct patients to 6916 0190.

- Application to be ART providers
  - Clinic who are not currently providing ART can register for an ART licence at www.go.gov.sg/art-application. Please note that no licence fee needs to be paid for onsite clinic ART applications and that these onsite ART applications are treated as approved upon application submission.
  - For PHPCs, please ensure that you select "Yes" to "Do you want to provide government-funded ART for ARI patients?".

- If you are non-PHPC, or providing private-paid ART, please select "Yes" to "Do you want to provide privately-funded ART?".

- Please remember to submit the correct protocol tag into iConnect/PRPP.
  - If you have submitted a Protocol 1 tag for a Protocol 2 (Primary Care) patient who is COVID-positive, no further action is needed. They will be further assessed by MOH and will generally still recover at home. If you have submitted a Protocol 2 (Primary Care) or Protocol 2 tag for a Protocol 1 patient who is COVID-positive, please contact CMTG immediately with the details (via email or via phone).
  - Please note that patients who visit multiple clinics and have multiple tags submitted may not have the correct public health actions triggered. As such, if you are placing your patient on Protocol 1, please ask your patient to alert you if they have not been contacted by MOH within 48 hours. **If you are aware that your Protocol 1 patient has not been contacted by MOH within 48 hours, please alert MOH** (via your AIC account manager or CMTG if your patient requires conveyance to an appropriate care facility).
  - Please ensure that you have submitted an NRIC/FIN for persons with NRIC/FIN. The protocol tag submission may <u>not</u> be accepted by the system if you select "Yes" to "Does this person have a valid NRIC/FIN?" and do NOT provide an NRIC/FIN. If you wish to submit via passport number, please select "No" for this question and indicate the Nationality. Protocol Tag submissions for passport numbers without Nationality will <u>not</u> be accepted.

<u>Revision of Healthcare Protocols</u>

1. **What are the Healthcare Protocols?**
   The following table summarizes the various protocols:

Protocol	**Care Involved**
Protocol 1 Patients who have been identified to be of higher medical risk **<u>OR</u>** symptomatically unwell	a. Administer dual swabs (ART and PCR) and issue a Medical Certificate (MC) for up to 5 days. Inform the patient that they should stay home and should self-isolate for the duration of the MC or until PCR result is negative (the legal requirement to stay home has been removed), whichever is earlier**.** b. If tested PCR-positive, these persons will continue on the existing management approach, i.e., MOH will follow-up with them and provide instructions, including assessing suitability to self-isolate at home and whether they need to be conveyed to a care facility. If they are at a facility, they should take guidance from their doctor on their discharge date. In general, such persons should self-isolate for at least 72 hours after the test result. If there is no further guidance from their care facility, they can resume normal activities and cease isolation when they self-test ART negative when after 72 hours, OR upon time-based discharge on 12 noon of Day 7 (for vaccinated individuals or below 12 years old) or Day 14 (for unvaccinated individuals, and are 12 years old and above), where Day 1 is the date of the **provider-administered** ART test.

Protocol	Care Involved
	c. If unwell or high-risk persons refuse a PCR swab test, including those under the suspect case criteria, please continue to issue 5-day MC, and inform patients that they should stay home for that duration, as per **Circular 174/2020** and **Circular 202/2020**.
Protocol 2 (Primary Care) Low medical risk **AND** mildly symptomatic individuals	a. These persons would only require a provider-administered ART swab. b. If tested ART positive or if patient refused an ART swab, doctors should provide a 5-day MC[7]. There is no legal requirement to stay home. c. Advise these patients to self-isolate for at least 72 hours after the test result. They can resume normal activities and cease isolation when they self-test ART negative after 72 hours (i.e., from Day 4 onwards where Day 1 is the day of the test result). d. For patients who persistently self-test ART positive, they should continue to self-isolate at home. They may exit self-isolation upon a negative self-test ART OR upon time-based discharge on 12 noon of Day 7 (for vaccinated individuals or below 12 years old) or Day 14 (for unvaccinated individuals, and are 12 years old and above), where Day 1 is the date of the **provider-administered** ART test. e. Advise the patient to return to his GP if his symptoms worsen or do not improve. Call 995 if there is an emergency. f. If patients insist on getting a PCR test, or had gotten a PCR test (e.g. pre-departure test, on-arrival test, or rostered routine test, etc.), but are assessed to be low-risk with mild symptoms, doctors may continue to manage them under Protocol 2 (Primary Care).
Protocol 2 Low medical risk **AND** asymptomatic persons who test ART positive	a. Self-isolate for at least 72 hours after the test result. Such persons can resume normal activities and cease self-isolation if they subsequently self-test ART negative after 72 hours (i.e., from Day 4 onwards). b. Similarly, for who persistently self-test ART positive, they should continue to self-isolate at home. They may exit self-isolation upon a negative self-test ART OR upon time-based discharge on 12 noon of Day 7 (for vaccinated individuals or below 12 years old) or Day 14 (for unvaccinated individuals 12 years old and above and are 12 years and above), where Day 1 is date of first positive ART test.

[7] The 5-day MC is to cover expected duration needed for symptom recovery and minimize returns to clinic for extension of MC, in the event that initial self-administered ARTs after 72 hours remain positive.

Protocol	Care Involved
	c. There is no need to see a doctor. If they do, doctors may advise them to rest. No additional COVID-19 test is needed. Doctors may provide a regular MC, which does not carry a legal obligation to remain at home, based on clinical discretion. d. Asymptomatic persons who test ART positive under a provider-administered ART swab should also be placed on Protocol 2. e. Asymptomatic persons who test PCR positive should also be managed under Protocol 2.

2. Why do persons under Protocol 1 still require dual swabs?

Persons who are symptomatically unwell or high-risk have been assessed to require higher level of care and may be required to be sent to a cohorted facility for treatment and recovery. A dual swab is necessary as ART enables an immediate diagnosis whilst the PCR provides additional confirmation and enables additional care to be carried out, e.g. patient may be sent to a cohorted setting where the patient may be administered COVID-19 therapeutics as well, where necessary. Dual swabs also avoid the risk of a false negative ART, which is of significant concern for individuals who are high risk for deterioration.

3. Will ART swabs be an accepted test modality to diagnose a patient as C+?

Yes. From 6 January 2022, symptomatic low-risk persons who undergo a healthcare administered ART swab and test ART positive will be accorded recovered status for purpose of exemptions from Rostered Routine Testing (RRT), Health Risk Warning (HRW). Unvaccinated recovered will be eligible for VDS. For more information on eligibility for VDS, please refer to https://go.gov.sg/vdsmminfo.

4. How do we reassure the public that the results are not a false positive without a PCR swab?

Data analysed from the test results of our local population has shown that positive predictive value (PPV) for healthcare-administered ART in symptomatic persons stands at 98.1%. PPV is defined as the probability that individuals with a positive test result truly have the disease, i.e. COVID-19 in this case. There is no test that has a PPV of 100% but the PPV from our local data is reassuring.

5. For Medical Certificates issued to individuals under Protocol 1 or Protocol 2 (Primary Care), is there a legal requirement to stay home? Can the GP adjust the duration of the Medical Certificate?

The Medical Certificate issued by the GP under Protocol 1 or Protocol 2 (Primary Care) does not include a legal requirement for patients to stay at home. However, patients under Protocol 2 (Primary Care) are encouraged to rest and self-isolate at home as much as possible and they should only leave their homes for purposes such as for further medical attention.

Although the recommended MC duration is 5 days, doctors have clinical discretion in further extending the duration, as appropriate. Patients are advised to return to their GP if your symptoms worsen or do not improve with time.

6. **How can we be sure that persons are no longer infectious when they exit self-isolation?**

Singapore constantly adjusts our medical policies and national strategy in dealing and living with COVID-19, especially in light of a highly transmissible Omicron variant.

With better understanding of COVID-19, better protection through vaccinations and better treatment modalities, Singapore is in a stronger position to transit toward living with COVID-19. A new balance is needed to allow the vast majority of COVID-19 patients to return back to normal activities as soon as possible.

ART tests are able to detect viable virus fragments in patients with high viral load, i.e. cycle threshold (Ct) <30. Persons who test ART negative are likely to be non-infectious as Ct>30, indicating low viral load.

Key to living with COVID-19 is to promote civic-minded and socially responsible behaviour in our society.

7. **What if my patient refuses a swab test?**

For individuals who refuse to be swabbed, medical professionals may issue a 5 Day MC and encourage the patient to self-isolate to protect themselves and their loved ones.

8. **For children under 5 years who has ARI, if the parents are only agreeable to an ART swab for the child, will the cost of ART be covered? Previously, if they decline the PCR, the cost of the ART is borne by patients.**

Yes, the cost of the ART swab will now be covered if the child was swabbed at a PHPC.

9. **Do patients on MCs issued under have to appear at court even if ART positive?**

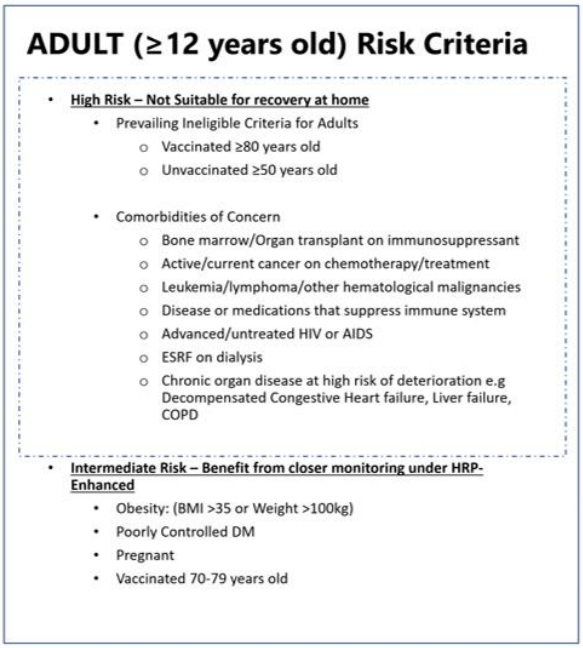
Regular MCs will not exempt persons from court appearances. Such persons should inform Courts that they are ART+/ PCR+ and seek guidance accordingly.

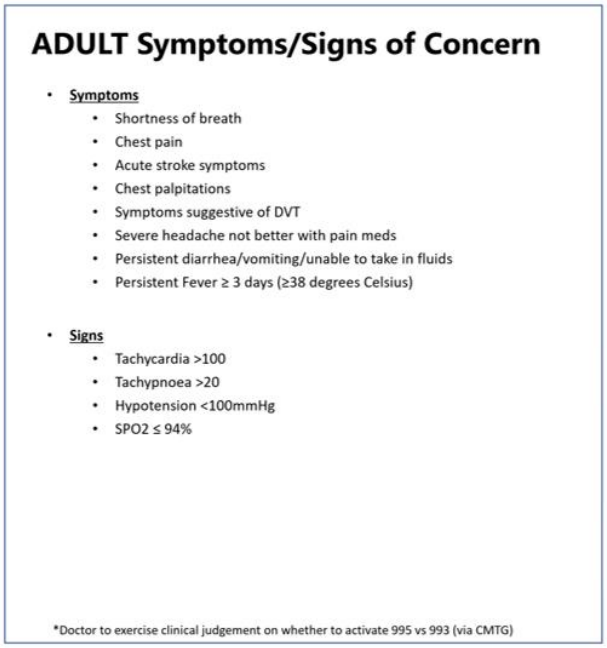
Assessment Criteria

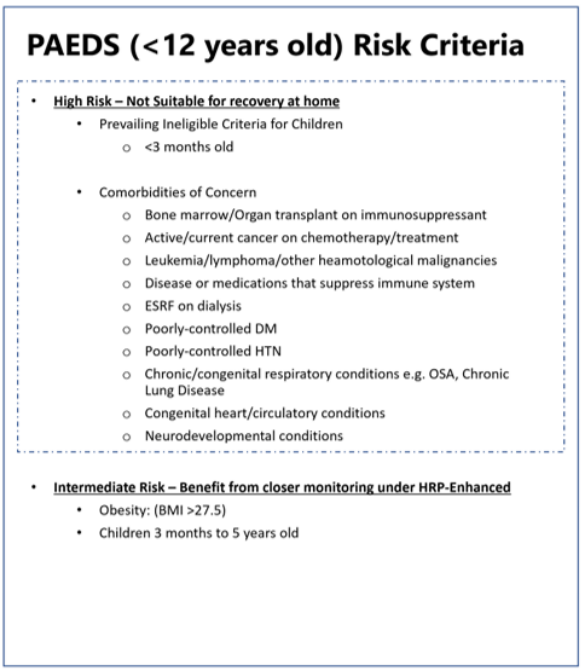
10. With the new approach, how should Primary Care Physicians assess one's eligibility for each protocol?

Medical professionals may wish to refer to Annex A of the MOH Circular "Rationalization and Streamlining of Healthcare Protocols" for the list of risk factors that guide the identification of patients for Protocol 1, 2 (Primary Care) and 2. MOH has also provided a comprehensive script guide for medical professionals to use as reference when assessing their patients' eligibility for each protocol, if needed.

11. What are considered symptoms and signs of concern?

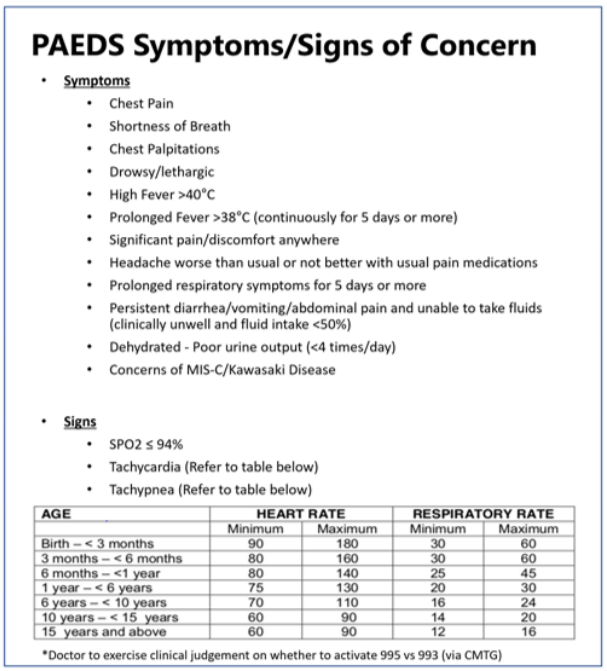






PAEDS (<12 years old) Risk Criteria

- **High Risk – Not Suitable for recovery at home**
  - Prevailing Ineligible Criteria for Children
    - <3 months old
  - Comorbidities of Concern
    - Bone marrow/Organ transplant on immunosuppressant
    - Active/current cancer on chemotherapy/treatment
    - Leukemia/lymphoma/other heamotological malignancies
    - Disease or medications that suppress immune system
    - ESRF on dialysis
    - Poorly-controlled DM
    - Poorly-controlled HTN
    - Chronic/congenital respiratory conditions e.g. OSA, Chronic Lung Disease
    - Congenital heart/circulatory conditions
    - Neurodevelopmental conditions
- **Intermediate Risk – Benefit from closer monitoring under HRP-Enhanced**
  - Obesity: (BMI >27.5)
  - Children 3 months to 5 years old



PAEDS Symptoms/Signs of Concern

- **Symptoms**
  - Chest Pain
  - Shortness of Breath
  - Chest Palpitations
  - Drowsy/lethargic
  - High Fever >40°C
  - Prolonged Fever >38°C (continuously for 5 days or more)
  - Significant pain/discomfort anywhere
  - Headache worse than usual or not better with usual pain medications
  - Prolonged respiratory symptoms for 5 days or more
  - Persistent diarrhea/vomiting/abdominal pain and unable to take fluids (clinically unwell and fluid intake <50%)
  - Dehydrated - Poor urine output (<4 times/day)
  - Concerns of MIS-C/Kawasaki Disease
- **Signs**
  - SPO2 ≤ 94%
  - Tachycardia (Refer to table below)
  - Tachypnea (Refer to table below)

AGE	HEART RATE		RESPIRATORY RATE	
	Minimum	Maximum	Minimum	Maximum
Birth – < 3 months	90	180	30	60
3 months – < 6 months	80	160	30	60
6 months – <1 year	80	140	25	45
1 year – < 6 years	75	130	20	30
6 years – < 10 years	70	110	16	24
10 years – < 15 years	60	90	14	20
15 years and above	60	90	12	16

*Doctor to exercise clinical judgement on whether to activate 995 vs 993 (via CMTG)

The tables provide a non-exhaustive list of signs and symptoms that warrant urgent/emergent medical care and, hence, is not suitable for recovery at home (including Protocol 2 (Primary Care)).

We will defer to the clinician's clinical judgement on whether a patient should be conveyed to a hospital for further management. For emergencies, 995 should be activated for immediate conveyance to the nearest emergency department. For non-emergencies, 993 ambulance can be activated via CMTG.

12. What if my patient has co-morbidities that I feel require closer monitoring but are not included in the Eligibility Criteria?

We defer to the clinician's clinical judgment on whether a patient is suitable for Protocol 1 or Protocol 2 (Primary Care). The clinical guidelines provided to the GPs serve as a guide. However, they are not a replacement for clinical judgment. You can proceed to place the patient on Protocol 1 should you be concerned after assessing the patient. Do document the clinical reasoning in your clinical records.

13. Where do I indicate the patient's suitability for the different Protocols?

Please continue to use Patient Risk Profile Portal (PRPP) and iConnect.COVID to indicate if an individual is suitable for Protocol 1, Protocol 2 (Primary Care) or Protocol 2. Clinics are recommended to submit Protocol indicators (Protocol 1 / Protocol 2 (Primary Care) / Protocol 2) after you have assessed the patient. Kindly ensure that you tag the patient to the appropriate Protocol.

If you have submitted a Protocol 1 tag for a Protocol 2 (Primary Care) patient who is COVID-positive, no further action is needed. They will be further assessed by MOH and will generally still recover at home. If you have submitted

a Protocol 2 (Primary Care) or Protocol 2 tag for a Protocol 1 patient who is COVID-positive, please contact CMTG immediately with the details (via email or via phone).

Please ensure that you have submitted an NRIC/FIN for persons with NRIC/FIN. The protocol tag submission may not be accepted by the system if you select "Yes" to "Does this person have a valid NRIC/FIN?" and do NOT provide an NRIC/FIN. If you wish to submit via passport number, please select "No" for this question and indicate the Nationality. Protocol Tag submissions for passport numbers without Nationality will not be accepted.

14. What if I have assessed a patient to be suitable for Protocol 2 (Primary Care) but he/she demands an additional PCR test?

Please reassure your patient that the positive predictive value (PPV) for healthcare-administered ART in symptomatic persons stands at 98.1% and is a reliable test modality. In addition, patients under Protocol 2 (Primary Care) will be accorded recovery status similar to those in Protocol 1.

Do clarify with the patient that performing a PCR will not change management, as he/she will still be managed as per Protocol 2 (Primary Care) even if PCR+.

For patients assessed as Protocol 2 (Primary Care) but who insist on a PCR test (even after being discouraged from doing so), clinicians may do so but should inform patient that this PCR swab will be privately charged and Protocol 2 (Primary Care) still applies.

15. Which protocols should asymptomatic individuals who incidentally tested ART+ or PCR+ (including tests done for Pre-Departure testing (PDT), Pre-Event Testing (PET), Routine Rostered Testing (RRT), or personal concerns) flow into?

For asymptomatic low-risk persons who incidentally test ART+ or PCR+ (including PDT/PET/RRT/other reasons), please triage them to Protocol 2 and submit their Protocol tag accordingly. There is no need to perform any further tests.

However, should the asymptomatic individual be deemed high risk, please tag them as Protocol 1 (this includes performing a PCR test for individuals who have not had one performed).

16. How will COVID-19 positive persons with vulnerable households (e.g. unvaccinated elderly parents) be managed?

If they can self-isolate during their recovery period, they may choose to stay home or make other arrangements such as paid lodging or moving the vulnerable household to other residences.

If not, please escalate these cases to CMTG at 6435 4060 or CMTG_Call_Centre@moh.gov.sg. Patients who are unable to self-isolate and

request for conveyance to an isolation facility will be assessed on a case-by-case basis. In general, only requests by COVID-19 individuals who are unable to self-isolate due to their financial difficulties, poor living environment and have high-risk household member would be considered. Please inform the patients that they may be placed in the same room as another COVID-19 individual.

17. Are patients who live in a shared room suitable for Protocol 2 (Primary Care)?

As far as possible, patients and/or housemates should attempt to make the necessary arrangements to support self-isolation of the affected individual and minimize interaction with others.

Patients who are unable to self-isolate and request for conveyance to an isolation facility will be assessed on a case-by-case basis. Please advise your patient that not all requests may be acceded to. In general, only requests by COVID-19 individuals who are unable to self-isolate due to their financial difficulties, poor living environment and have high-risk household member would be considered (e.g. unvaccinated elderly 80 and above or immunocompromised household member). Please also inform the patients that they may be placed in the same room as another COVID-19 individual.

These patients will be conveyed to a designated isolation facility arranged by CMTG.

Support for Persons under Protocol 2 (Primary Care)

18. If my clinic does not provide ART, can I refer my patients to other SASH clinics or polyclinics to provide the government-funded ART?

We encourage all clinics to provide ART as soon as possible to help your patients who require a healthcare-administered ART swab.

Clinics who need to refer patients under Protocol 2 (Primary Care) for ART, **please refer patients to SASH PHPCs for ART swabs under Protocol 2 (Primary Care) as far as possible. ART Referrals to Combined Test Centres (CTCs) are possible on a walk-in basis for now (i.e., cannot be booked on PRPP). If you refer to CTCs, please manage patients' expectations that there may be a queue due to the walk-ins.** Please do not refer patients to Polyclinics as they are unable to take these walk-ins. For now, clinics will not be able to view ART results from CTCs and Polyclinics and system enhancements are on-going.

Please use the hardcopy referral form (provided separately) to refer patients for ART during this period; please see instructions in the PRPP manual.

For patients under Protocol 1, there is no change. You may continue to refer them to SASH clinics/CTCs/polyclinics for the dual ART and PCR swabs via the existing approach.

19. Will there be mandated check-ins for elderly patients with co-morbidities on Protocol 2 (Primary Care)?

Regardless of age, please advise your patients to return to your clinic or seek the appropriate medical attention should their condition deteriorate. Should the patient have concerning symptoms that require immediate medical attention, please advise them to call 995. (including calling 995 for any medical emergencies).

Any subsequent visits to your clinic within 10 days from the first positive test will still be claimable under the existing applicable subsidy schemes.

20. Is the participating PHPC expected to deliver medications to patients who test positive for COVID?

No. Primary care providers should ensure that an adequate supply of medications is prescribed at the first point of consultation. Should patients require a top-up of acute medications, please advise them to return to your clinic.

For chronic medications, please advise them to approach their original doctor for this. If the patient's supporting doctor for their chronic condition is from the polyclinic (even if swabbed at PHPC), please advise the patient to contact his/her polyclinic to arrange for chronic medication refill. If they wish to obtain it from your clinic, your clinic may charge them for this, subject to prevailing guidelines and subsidy policies.

21. Where can the persons under Protocol 1 and 2 (Primary Care) obtain the ART kits? Do they need to upload their ART daily? Are factsheets available for dissemination to the patients?

Persons under Protocol 1 and 2 (Primary Care) will receive an SMS with instructions to obtain ART kits from vending machines. There is no requirement for individuals to upload their ART test results.

22. Will household members of persons under Protocol 1 and 2 (Primary Care) be placed on Health Risk Warning? Will they be allowed to withdraw ART kits from the vending machines as well?

Kindly remind patients under Protocol 1 and 2 (Primary Care) to register their household contacts for HRW. Thereafter, household members will be issued a Health Risk Warning. Do advise them to monitor their health for the next 7 days and the need for an ART negative test prior to leaving home. Household members issued HRW will be able to obtain ART kits via vending machines, if required.

23. What should the PHPC do if the patient is assessed to be unwell or no longer suitable for Protocol 2 (Primary Care)?

If the patient's condition worsens or is in need of conveyance to an isolation facility, please contact CMTG at CMTG_Call_Centre@moh.gov.sg or 6435 4060 or to activate conveyance to hospital / isolation facility. For patients who are medically unstable, please contact 995 for immediate conveyance.

Please note that a PCR test may be necessary for confirmation prior to sending this patient to a cohorted setting where the patient may be administered COVID-19 therapeutics as well. Please consider administering the PCR test prior to conveyance as far as possible.

24. If the patient under Protocol 1 or Protocol 2 (Primary Care) remains symptomatic, can they leave home if they test ART negative or after 7 days (for vaccinated individuals and children below 12 years old) /14 days (for unvaccinatedindividuals aged 12 years and above) respectively?

Yes, a Protocol 1 or 2 (Primary Care) patient can deisolate if they test ART negative after 72 hours or upon time-based discharge of 12 noon on Day 7 (for vaccinated individuals and children below 12 years old) / Day 14 (for unvaccinated individuals aged 12 years and above), whichever is earlier. (Note: Day 1 is taken as date of first positive ART result).

If the patient remains unwell, the patient is advised to return to the managing GP (or their regular GP/Polyclinic) to seek further medical consult and for further MCs, if required. These patients can be treated by PHPCs under the Flu Subsidy Scheme (FSS), if eligible.

25. Can PHPC arrange for an exit PCR swab if patients request for it?

Please inform the patient that Govt-funded exit swabs are no longer available nor necessary for individuals in Protocol 2 (Primary Care) to exit from self-isolation. After an initial self-isolation period of 72 hours, individuals can exit self-isolation upon a negative self-administered ART. Patients who persistently test ART positive, can exit self-isolation via time-based discharge on 12 noon of Day 7 (for vaccinated individuals and children below 12 years old) / Day 14 (for unvaccinated individuals aged 12 years and above) respectively.

Should the patient still request for an ART or PCR, please inform them that this will be privately charged to them.

26. Any dedicated hotline and/or email for Protocol 2 (Primary Care)?

For PHPCs/GPs/Polyclinics:

- Please contact 6916 0193 (MOH hotline) if you have any queries regarding the Protocol 2 (Primary Care). This is an interim number, effective until **7 Feb 2022** (inclusive). Please do not provide this number to patients.
- Please contact CMTG at 6435 4060 / CMTG_call_centre@moh.gov.sg, if you have any queries pertaining to 993 ambulance services,

arrangement of conveyance to an isolation facility, or other case management issues.

For Patients:

- Please contact 6916 0190 (MOH hotline) for more information on the Protocol 2 (Primary Care). This number is also found in patient's information sheets/online resource.

27. Drawing reference to the Home Recovery Programme (HRP), will there be buddies for persons under Protocol 2 (Primary Care)?

There will not be dedicated buddies for persons under Protocol 2 (Primary Care) as the primary care doctor will continue to care for patients. However, should there be any administrative queries, please inform your patients to contact MOH Hotline at 6916 0190.

During the initial roll-out period, Protocol 2 (Primary Care) patients can also still access Telemedicine Providers during after-office hours via go.gov.sg/telemedicineproviders.

28. Will recovery memos be provided for patients under Protocol 2 (Primary Care)? If not, are clinics able to provide this on their behalf?

Recovery memos will not be issued by MOH. PHPCs/GPs may choose to provide such a recovery memo, at their own discretion.

29. The employer requires a negative PCR swab result, before the employee can return to work. Should this swab then be provided by PHPCs?

Protocol 2 (Primary Care) patients can be discharged from self-isolation upon a negative self-administered ART test after 72 hours (from time of first positive test) or upon time-based discharge of 12 noon on Day 7 for vaccinated individuals or below 12 years old/ Day 14 for unvaccinated individuals 12 years old and above respectively), whichever is earlier. (Note: Day 1 is taken as date of first positive ART result)

If the patient states that a PCR swab is needed, this will be a private-paid swab.

30. If the COVID-19 positive patient developed URTI after exit, does the PHPC swab the patient again?

The patient does not need to be swabbed again for up to 90 days, given that the risk of reinfection within 90 days of past infection is very low and there may be a high possibility of testing false positive due to viral shedding. However, the doctor may assess and choose to swab the person based on clinical discretion and highlight the case to CMTG if indeed positive.

31. For patients who have been referred to other clinics for SASH, is the referring doctor the doctor in charge of any follow-up for the patient? Can

the SASH clinic claim for the consult if the patient presents more than 48 hours after referral?

For patient referred out for ART/PCR swabs, the referring doctor remains responsible for care of the patient. The SASH clinic can claim from FSS for the consultation fee, if the patient presents more than 48 hours of the referral.

32. **For positive patients who are on Protocol 2 (Primary Care) but returned to the clinic and were assessed to require emergency care subsequently, are the PHPCs and polyclinics required to perform a PCR test at the clinics before their conveyance to the Emergency Departments?**

    The clinic does not need to perform a PCR test prior to patient's conveyance to the Emergency Department (ED) via 995. The ED will perform the necessary tests (including a PCR test) accordingly, based on clinical assessment.

Other Protocol 2 (Primary Care) matters

33. **If a person under Protocol 2 (Primary Care) is not provided a recovery memo, how does one certify that they have recovered from COVID-19 and are allowed to travel?**

    In general, travelers must adhere to the prevailing testing requirements of the destination country.

    In the event a recovery memo is recognised and/or required, the GP can provide such a memo on his own accord.

34. **If a traveller is an asymptomatic person and presents at my clinic asking to be tested and placed on Protocol 2 (Primary Care), should I provide the ART or PCR swab as requested? Will this swab be funded by the Government? What if he is high-risk?**

    For travellers, if tested positive, they should be placed on Protocol 2 rather than Protocol 2 (Primary Care) as they are asymptomatic. These swabs will not be government-funded. If the traveller is deemed to be of high-risk and has separately tested positive on a mandatory traveller test (e.g. a self-administered ART under the testing regime for Vaccinated Travel Lanes), a confirmatory PCR test should be administered and the traveller placed on Protocol 1 in line with their high-risk status.

35. **If a traveller is symptomatic and presents at my clinic asking to be tested and placed on Protocol 2 (Primary Care), should I provide the ART or PCR swab as requested? Will this swab be funded by the Government? Do his existing travel isolation requirements continue to hold?**

    Yes, if the person is symptomatic, please review the patient as per the current ARI workflow and place them on the appropriate protocol as determined by his/her risk factors. The swab will be funded by the Government under ARI

testing. The existing travel isolation requirements will be replaced by the Protocol that you have placed the patient on.

36. Should household members not receive a Health Risk Warning, who should the PHPC/TM provider direct them to?

Please remind the COVID-19 positive individual to register household members as close contacts, following instructions on the SMS received. If the patient has not received the SMS from MOH, they may contact MOH at 6916 0190.

The doctor should remind the COVID-19 individual to self-isolate and minimize interaction with others.

37. Is it mandatory for HH members to isolate themselves before the HRW is issued to them?

Patients should be reminded of their social responsibility to curb the spread of infection by minimising movement in the community and remaining isolated at home.

Household members are advised to self-administer an ART test and ensure the result is negative before leaving home

38. If household members under HRW turn ART positive, are other HH members' HRW extended again?

For household members under HRW who test ART positive, they should proceed to self-administer Protocol 2 (as per current practice), which includes self-isolating him/herself until a negative ART result.

There will be no extension of HRW for the rest of the household members. However, the remaining household members are advised to continue monitoring their health and to minimize social interaction with members of the public/people outside their household.

In the event the household member who tested ART positive feels unwell/develops symptoms, he is advised to see a doctor. If the doctor confirms the diagnosis of COVID-19 and onboards the patient onto Protocol 1 or Protocol 2 (Primary Care), then a new set of HRWs will be issued to all close contacts of this newly diagnosed COVID-19 case. This is as aligned to current evidence showing that symptomatic individuals are more infectious.

39. If patient completes Protocol 2 (Primary Care) and is discharged from self-isolation, but HH member on HRW turned ART Positive on D9, will the discharged patient need to register for HRW again?

No, the recovered patient will not be required to register for HRW again. However, he is strongly advised to minimise interactions with household members during his/her recovery.

40. For Protocol 2 (Primary Care) patients who require help with food delivery, who can they contact?

As far as possible, patients should either order in food deliveries and/or seek the help of household members.

Patients are reminded to only leave home for essential activities (for e.g. Seeking medical assistance) during this period of self-isolation. In the event the patient really needs to leave his/her house, he/she should minimize social interactions and avoid crowded areas.

If GPs encounter any patients requiring help, do inform AIC account managers, who can help to seek assistance for these patients too.

41. If the Protocol 2 (Primary Care) patients are currently following up at the polyclinics for their chronic conditions, can they request for chronic medications from the polyclinics?

Yes, existing patients may contact the polyclinics, where they are following up at, to arrange for medication delivery for their chronic conditions if needed.

42. How should PHPCs obtain the government-funded ART kits?

Clinics who are not currently providing ART can register for an ART licence at www.go.gov.sg/art-application. Please note that no licence fee needs to be paid for onsite clinic ART applications and that these onsite ART applications are treated as approved upon application submission.
For PHPCs, please ensure that you select “Yes” to “Do you want to provide government-funded ART for ARI patients?”.
If you are non-PHPC, or providing private-paid ART, please select “Yes” to “Do you want to provide privately-funded ART?”.
After registering for the ART licence, clinics need to submit a request via https://form.gov.sg./60dbcf3c44704800125974c5 for the first load of ART kits to be triggered by AIC. Clinics will receive the ART kits within 1 week.

Applicable to all PHPCs only: To request for a re-supply of ART kits, please fill in your details at https://form.gov.sg/#!/60a1bfb6f213280011c6785f.

For all unused ART kits provided by MOH, please hold the kits until informed in writing by MOH to return the kits. Clinics will be audited on its use of the test kits provided by MOH, using submissions on the Patient Risk Profile Portal (PRPP).